

**Tri-Lakes Relational Center Springfield**  
 · 2131 S. Eastgate Ave · Springfield MO 65809 ·  
 P. 417.496.1867 · F. 773.496.1867

**Intake Information**

*The information in this form is confidential. If you are coming for couples or family counseling please **fill out a separate form for each person who will be seen** and keep your answers private. Please print clearly. Thank you.*

**General Information**

Today's Date		Name		Birth Date	
Current Age	Gender	M	F	Social Security #	
Home Phone #		Cell Phone #		E-mail	
Address					
City			State		Zip Code
Emergency Contact Person			Phone #		Relation

List the persons with whom you are now living, their relationship to you, and ages.

Calls or e-mail will be discreet, but please indicate any restrictions

Single	Married	Divorced	Re-Married	Length of current relationship: Dated	Married
Spouses Name		Birth Date	Current Age	SS#	

Children (and ages) not listed above as living with you.

**Referral:** Who gave you my name to call? Where did you hear about us? How did you find our website?

Name of Referral Source	Phone #
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If applicable, may I have your permission to thank this person for the referral?      YES      NO

How did this person explain how I might be of help to you?

**Religious / Spiritual identification**

Religious denomination/ affiliation

Involvement:      None      Some/irregular      Active

How important are spiritual concerns in your life?

Which (if any) church or meeting are you involved?

In your own words, how would you describe the spiritual part of your life?

Would you like your counselor to integrate Christian spirituality into your counseling?      YES      NO

**Your medical care:** From whom or where do you get your medical care?

Clinic/ doctor's name	Phone #
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If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?      YES      NO

Are you currently under the care of a physician, receiving medical care of any sort, or taking any medication?

When was the last time you were seriously ill or had medical treatment and for what (including pregnancy/ abortion)?

Do you or anyone in your family have a history of nervous, mental, or emotional disorders?

Do you or anyone in your family have a history with alcoholism or drug addiction?

Have you been to counseling before? If so, briefly describe your experience.

## **Problem Information**

Briefly describe what brings you into counseling.

When did you first notice the problem and what helped you realize there was a problem?

Why are you coming to counseling **now** instead of 3 months ago or 3 months from now?

In coming to counseling, what do you hope to accomplish? What are your goals for counseling?

If counseling accomplished exactly what you hope it to, how would you know it? What would look different in your life?

What current stressors are “not helping” the situation?

## Background Information

Briefly describe your mother,

father, and

their relationship with each other.

Describe your relationship with your parents and where you “fit” in your family of origin.

If your parents divorced, when did it occur and what was your reaction to it?

Give your impressions of the atmosphere of your home growing up, including how people got along.

How was love expressed in your home growing up?

How was anger expressed?

What were your parents’ attitudes about sex and was there any discussion or instruction about sexuality in the home?

Were you or your siblings ever physically and/ or sexually abused, assaulted or neglected?

How would you describe your peer relationships? (same/opposite sex, married/single, close/distant, many/few, etc.)

Is there any other background information that you think might be important for me to know about you?  
*If you need more space feel free to continue on the back of this sheet.*

**Please check all that apply**

- I am dissatisfied in my relationship with my spouse or significant other.
- I am dissatisfied with, confused with, or have questions about the sexual part of my life.
- My relationships, in general, are unfulfilling.
- In the last 3 months I have thought about how I could end my life.
- I am dissatisfied with my life and want a change.
- I am not happy with my body.
- I am not happy with the way others perceive me.
- The "me" inside and the "me" others know are not the same.
- I am not happy with the current state of my family life.

**In the last 3 months I have attempted the following, trying to feel better about my life...**

- |  |  |
|--|--|
| <input type="checkbox"/> binge eating  | <input type="checkbox"/> was destructive to property                     |
| <input type="checkbox"/> drank alcohol                                       | <input type="checkbox"/> controlled my eating                            |
| <input type="checkbox"/> taken prescription or no prescription medications   | <input type="checkbox"/> refused to get out of bed, or do normal hygiene |
| <input type="checkbox"/> used illegal drugs                                  | <input type="checkbox"/> ignored my normal responsibilities              |
| <input type="checkbox"/> acted sexually in a way that is unusual for me      | <input type="checkbox"/> isolated myself from people                     |
| <input type="checkbox"/> used pornography, erotic fantasy, or erotic stories | <input type="checkbox"/> surrounded myself with people constantly        |
| <input type="checkbox"/> masturbated   | <input type="checkbox"/> worked more than usual                          |
| <input type="checkbox"/> harmed myself by cutting, burning or other means    |  |

**In the last 3 months I have experienced...**

- |   |   |
|---|---|
| <input type="checkbox"/> moodiness                                | <input type="checkbox"/> persistent physical ailment          |
| <input type="checkbox"/> unusual anger or irritability            | <input type="checkbox"/> difficulty sleeping or sleeping more |
| <input type="checkbox"/> feelings of hopelessness or helplessness | <input type="checkbox"/> unusual fatigue                      |
| <input type="checkbox"/> change in sex drive                      | <input type="checkbox"/> mental confusion or disorientation   |
| <input type="checkbox"/> change of appetite                       | <input type="checkbox"/> decreased energy or motivation       |
| <input type="checkbox"/> feelings of grief or sadness             | <input type="checkbox"/> anxious feelings                     |
| <input type="checkbox"/> emotional numbness                       | <input type="checkbox"/> inability to relax                   |

**In my life time I have experienced...**

- |   |   |
|---|---|
| <input type="checkbox"/> the loss of a loved one        | <input type="checkbox"/> having been abandoned by important people in my life             |
| <input type="checkbox"/> a traumatic event              | <input type="checkbox"/> being taken advantage of by important people in my life          |
| <input type="checkbox"/> sexual abuse or assault        | <input type="checkbox"/> being unloved or not good enough for important people in my life |
| <input type="checkbox"/> physical abuse or assault      | <input type="checkbox"/> living with some one who had/has an addiction                    |
| <input type="checkbox"/> mental or verbal abuse         | <input type="checkbox"/> an addiction of my own   |
| <input type="checkbox"/> the loss of someone by suicide | <input type="checkbox"/> something unlisted that is significant to me (please explain)    |
| <input type="checkbox"/> the loss of a child            |   |
| <input type="checkbox"/> an abortion                    |   |
| <input type="checkbox"/> divorce of my parents          |   |
| <input type="checkbox"/> a divorce of my own            |   |
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